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DAVID E. JANSSEN
Chief Administrative Officer

June 13, 2007

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

SACRAMENTO UPDATE

Budget Conference Committee

High Risk Pest Exclusion Program. On June 12, 2007, the Conference Committee reached a compromise agreement and approved a $1,523,000 augmentation for county agriculture commissioners, and a $677,000 augmentation to expand vehicle pest inspections at border protection stations. The proposal was approved by a vote of 2 to 1 in the Assembly and 3 to 0 in the Senate.

Public Transportation Account Shift and Proposition 42 Spillover Revenue. A coalition including the California State Association of Counties (CSAC), League of Cities, Associated General Contractors, and California Chamber of Commerce have put forth an alternative to the County-opposed Assembly "spillover" proposal, which would add these revenues to the Proposition 42 revenues and change the distribution formula among State Transportation Improvement Program (STIP), cities, counties, and transit beginning in FY 2008-09 as follows:

- Reduce the STIP share from 40% to 35%
- Reduce the cities share from 20% to 15%

- Reduce the counties share from 20% to 15%

- Increase the transit share from 20% to 35%

The coalition proposal would protect both the spillover revenues for transportation purposes and the current Proposition 42 distribution formula. Specifically, the proposal would: 1) allocate 50 percent of the spillover portion to transit and 50 percent for general fund relief for the next three to five years by putting the revenues towards retirement of transportation bond debt; and 2) sunset this provision after three to five years and allocate the entire sales tax on gasoline through the existing Proposition 42 formulas, which are 40 percent STIP, 20 percent counties, 20 percent cities, and 20 percent transit.

According to CSAC, this proposal would provide a transition period for transit and the general fund to receive the total spillover in the short-term, but it poses no risk in the long-term for the other purposes funded by Proposition 42 when spillover becomes less predictable. CSAC indicates that this would also ensure that all sales taxes on gasoline are treated equally and dedicated for transportation purposes into the future that support the entire interconnected system.

Pursuit of County Position on Budget Items

Proposition 1B Funding for Local Streets and Roads. The Senate approved $400 million for one year of Proposition 1B funding for local streets and roads and the Assembly approved $600 million for the same purpose. Proposition 1B, which was approved by the voters in November 2006, authorized the sale of $19.925 billion of general obligation bonds for various transportation purposes. Of this amount, $2.0 billion is to be deposited in the Local Street and Road Improvement, Congestion Relief, and Traffic Safety Account of 2006.

The Governor's May Revision proposal included $600 million for FY 2007-08 which would be equally distributed between counties and cities. The Department of Public Works (DPW) expects to receive an estimated $58.2 million from the $300 million slated to be allocated to counties in FY 2007-08. Under the Senate version, DPW's share would be reduced by one third from $58.2 million to less than $39 million.

The May Revision Budget proposal also includes an additional allocation of $3.8 billion over the next three years, for a total allocation of $11.5 billion of the total approved amount of $19.925 billion, to fund other programs under Proposition 1B. An additional $1.3 billion is allocated in FY 2007-08. However, the funding levels for the Streets and

Roads Program remains unchanged with the County's direct allocation remaining at $58.2 million in FY 2007-08.

In light of this additional allocation of bond funding for other programs in Proposition 1B as part of the FY 2007-08 State Budget, DPW is concerned that the State may not have sufficient bond financing capacity to fully allocate the remaining bond funds for the Local Streets and Roads Program beyond FY 2009-10 in a timely manner. Therefore, DPW recommends that the County support the Assembly approval of $600 million in the FY 2007-08 allocation of Proposition 1B funding for Local Streets and Roads.

Support for the Assembly version of Proposition 1B funding for local streets and roads is consistent with existing County policy to support the direct allocation of funds to local governments for the preservation of local streets and roads, without reducing other transportation funds or impacting other agencies, as well as Board Action on December 5, 2006 to maximize the amount of funding available to the County from the various bond acts. **Therefore, our Sacramento advocates will support the Assembly proposal to allocate $600 million under Proposition 1B for local streets and roads.**

Integrated Regional Water Management (IRWM). The IRWM Program is intended to promote and practice integrated regional water management to ensure sustainable water uses, reliable water supplies, better water quality, and other strategies. The Senate rejected the Governor's proposed funding for Proposition 84 (Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Act of 2006) and Proposition 1E (Flood Protection and Disaster Preparedness) IRWM ($257.9 million). The Senate did augment $20 million from Proposition 1E Stormwater Flood Management funding and approved Budget Bill Language specifying that Proposition 1E Stormwater funds be allocated for projects in the Northern Bay Area and Marin County.

The Assembly approved Proposition 84 IRWM funding and $100 million in Proposition 1E Stormwater funding as a separate program contingent upon legislation. DPW supports the Assembly's approval of a $100 million appropriation in Proposition 1E Stormwater Flood Management funding as part of the State's FY 2007-08 Budget to be allocated to the State Department of Water Resources (DWR) for the purpose of constructing projects through an early implementation program to manage stormwater runoff, reduce flood damage, and where feasible, provide other benefits including ground water recharge, water quality improvement, and ecosystem restoration. Projects implemented with these funds should (1) not be part of the State Plan of Flood Control in the Central Valley and (2) be consistent with any applicable integrated regional water management plan.

Even though DPW is not seeking an earmark, the department recommends support for the $100 million appropriation to DWR to enable the County to seek additional funding for the construction of the Big Tujunga Dam seismic rehabilitation and spillway modification project. This project will restore the flood management capabilities of the dam and also allow DPW to conserve an additional 4,500 acre-feet of stormwater each year. Support for the Assembly's proposal is consistent with existing policy to support legislation funding the planning, operation, and maintenance of watershed or multi-use projects. **Therefore, our Sacramento advocates will support the Assembly's $100 million appropriation to DWR.**

Health Care Reform Advances

On June 7, 2007, the two health care reform measures proposed by the Democratic leadership, AB 8 (Nuñez) and SB 48 (Perata), passed their respective houses of origin on partisan votes, with only Senator Lou Correa (D-Orange County) voting no on SB 48.

Assembly Speaker Nuñez and Senate President Pro Tem Perata characterized their proposals as very similar. Both bills propose to: 1) require employers to spend 7.5 percent of their payroll on health care or pay into a State pool, 2) subsidize insurance for children of families earning less than three times the Federal poverty level, and 3) require insurers to spend at least 85 percent of premiums on medical care. Workers in the State pool would be required to contribute toward the insurance premium. SB 48 would limit that contribution to five percent of income, while AB 8 has no cap. AB 8 would exempt businesses from the employer mandate that have been operating for three years or less, employ fewer than two people, or have an annual payroll of less than $100,000. SB 48 does not include this employer exemption. The major elements of the two proposals are summarized in Attachment I.

The Assembly debated AB 8 for over two hours and many members from both sides of the aisle spoke. Republicans objected to the 7.5 percent payroll fee on employers for employee health care coverage, indicating that it would amount to a job killer in California. Republicans also expressed concern over the lack of consideration paid to their alternative proposals. In the Senate, only Senators McClintock and Runner spoke against SB 48. Senator McClintock indicated that some states are experiencing problems with similar health care reform measures, including Massachusetts and Tennessee. Senator Runner acknowledged the existence of a health care crisis and offered to work with Senator Perata and others so that any bill going forward would be a bi-partisan effort. Senator Perata agreed to work with him and other interested Republicans, and suggested that a conference committee on health care reform could convene sometime in July or August.

Although legislative language on the Governor's health care reform plan has still not been released by the Administration, a Legislative Counsel opinion on the plan requested by Assembly Republican Rick Keene was recently provided to CSAC staff. Legislative Counsel determined that the fees to be assessed against employers, doctors and hospitals were actually taxes and would require a two-thirds vote of the legislature. However, Legislative Counsel cautioned that its conclusion was based only on the proposal and could change once it is in bill form with all the appropriate detail. The Legislative Counsel opinion is included as Attachment II.

We will continue to keep you advised.

DEJ:GK
MAL:IGR:acn

Attachments

c: All Department Heads
Legislative Strategist
Local 660
Coalition of County Unions
California Contract Cities Association
Independent Cities Association
League of California Cities
City Managers Associations
Buddy Program Participants

Health Care Reform Legislation

	AB 8 (Nuñez): *Fair Share Health Care* – As Amended May 17, 2007	**SB 48 (Perata):** *Toward Universal Health Care for California* – As Amended May 16, 2007
Coverage for Children	• establishes Medi-Cal eligibility for all children up to age 19 with family incomes up to 133 percent of the federal poverty level. • expands Healthy Families Program (HFP) eligibility from 250 percent to 300 percent of the federal poverty level. • eliminates federal citizenship and immigration requirements for children to enroll in Medi-Cal or HFP.	• establishes Medi-Cal eligibility for all children up to age 19 with family incomes up to 133 percent of the federal poverty level. • expands Healthy Families Program (HFP) eligibility from 250 percent to 300 percent of the federal poverty level after June 30, 2008, to the extent funds are appropriated for this purpose. • covers all children regardless of immigration status.
Coverage for Adults	• expands Medi-Cal eligibility to parents in families at or below 133 percent of federal poverty level, and expands HFP eligibility via a purchasing pool to uninsured parents of children enrolled in HFP with family incomes between 133 percent and 300 percent of federal poverty level by July 1, 2008. • removes the Medi-Cal eligibility asset test for children and families.	• expands Medi-Cal eligibility to parents in families at or below 133 percent of federal poverty level, and expands HFP eligibility via the purchasing pool to uninsured parents of children enrolled in HFP with family incomes between 133 percent and 300 percent of federal poverty level by July 1, 2008. • removes the Medi-Cal eligibility asset test for children and families.
Employer Responsibility	• requires specified employers by January 1, 2009 either to provide coverage to their full-time or part-time employees or pay a fee of an equivalent minimum amount into a state purchasing pool which would negotiate and contract with carriers for employee coverage. • establishes the amount of the employer's financial obligation as 7.5 percent of Social Security wages paid by the employer.	• requires specified employers by January 1, 2011 either to provide coverage to their full-time or part-time employees and their dependents or pay a fee of an equivalent minimum amount into a state purchasing pool which would negotiate and contract with carriers for employee coverage. • establishes the amount of the employer's financial obligation as 7.5 percent of Social Security wages paid by the employer.

	AB 8 (Nuñez): *Fair Share Health Care* – As Amended May 17, 2007	**SB 48 (Perata):** *Toward Universal Health Care for California* – As Amended May 16, 2007
Employer Responsibility (Cont'd)	• requires employers to establish cafeteria plans under Section 125 of the Internal Revenue Code to allow employees to share in the cost of coverage on a pretax basis. • exempts businesses from the employer mandate that have been operating for three years or less, employs fewer than two people or have an annual payroll of less than $100,000.	• requires employers to establish cafeteria plans under Section 125 of the Internal Revenue Code to allow employees to share in the cost of coverage on a pretax basis. • does not include employer exemption.
Employee Responsibility	• requires an employee eligible for Medi-Cal or HFP to enroll in health care coverage which is offered by their employer. • requires an employee contribution on a sliding scale based on income or selected plan. • does not include employee exemption.	• requires all taxpayers with incomes of 400 percent of the federal poverty level or greater to maintain a minimum policy of health care coverage for themselves and their dependents. • requires an employee health coverage contribution on a sliding scale based on income, selected plan, and number of covered dependents. • exempts those whose sole source of income is retirement income, or for whom the cost of health care coverage exceeds 5 percent of family income.
State Responsibility	• requires the Managed Risk Medical Insurance Board (MRMIB) to administer the State purchasing pool called CalCHIPP, negotiate favorable rates and contracts with health plans, and develop a standard form to screen applicants for individual health insurance coverage. • requires the Employment Development Department to administer and collect employer fees. • authorizes MRMIB to establish health plan premiums	• requires the Managed Risk Medical Insurance Board (MRMIB) to administer the State purchasing pool called the Connector, to negotiate rates for coverage, and to develop a standard form to screen applicants for individual health insurance coverage. • requires the Employment Development Department to administer and collect employer fees. • requires the Franchise Tax Board to use tax information to enforce the individual mandate. • authorizes the Connector to provide health care subsidies

	AB 8 (Nuñez): *Fair Share Health Care* – As Amended May 17, 2007	**SB 48 (Perata):** *Toward Universal Health Care for California* – As Amended May 16, 2007
State Responsibility (Cont'd)	and administer subsidies to eligible enrollees with incomes at or below 300 percent of the federal poverty level.	for eligible employees who are also eligible for HFP or Medi-Cal.
Insurance Market Reforms	• makes numerous insurance market reforms, including prohibiting exclusion of individual coverage based on health status, except for the list of exclusions developed by the Major Risk Medical Insurance Board. • requires insurance carriers to offer health coverage by January 1, 2008 to mid-size employers without any exclusion due to medical underwriting or any other criteria other than the employer's willingness to make the premium payments and meet reasonable participation requirements. • requires insurance carriers to use a standard form to screen applicants for individual health insurance coverage by July 1, 2008.	• requires insurance carriers to use the standard application form for individual health insurance and prohibits use of information on the form to decline coverage or to limit an individual's choice of plans. • requires insurance carriers to offer health coverage by January 1, 2008 to mid-size employers using the existing rating and medical underwriting requirements applicable to small employers. • authorizes plans to offer health discounts for those in weight loss programs, or disease management programs.
Cost Containment	• requires adoption of regulations by July 1, 2008 defining and limiting administrative costs so that at least 85 percent of revenues received by insurance carriers are spent on health care services.	• requires adoption of regulations by January 15, 2008 defining and limiting administrative costs so that at least 85 percent of revenues received by insurance carriers are spent on health care services.
Financing	• establishes the California Health Trust Fund for the purpose of providing coverage through CalCHIPP. • establishes employer fees. • requires individual cost sharing in the purchasing pool.	• establishes the Health Insurance Trust Fund for the purpose of providing coverage through the Connector. • establishes employer fees. • requires individual cost sharing in the purchasing pool.
Evaluation	• does not provide for evaluation.	• creates an advisory body to evaluate health care reform.

Attachment II

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Legislative Counsel of California

May 30, 2007

Honorable Rick Keene
Room 2158, State Capitol

REVENUE TO FUND HEALTH CARE - #0703058

Dear Mr. Keene:

You have submitted a 10-page document entitled "Governor Schwarzenegger's Health Care Proposal" (hereafter the proposal) and asked us to determine whether the charges proposed to be assessed against certain employers and against physicians and surgeons and hospitals would, if enacted, constitute a tax for purposes of Section 3 of Article XIII A of the California Constitution.

Preliminarily, we point out that our analysis is based solely on the description of these charges as set forth in the proposal. The determination of whether a charge constitutes a tax or a fee often turns on the details of the provisions imposing the charge. Because our opinion is based only on a proposal, we necessarily are without all the details that would be required for implementation of its provisions and that could affect a determination of whether these particular charges would constitute a tax or fee for purposes of Section 3 of Article XIII A of the California Constitution. Consequently, absent those details, we were required to make certain assumptions, and our conclusion could be affected to the extent our assumptions differ from the language of the proposal in bill form. That is, our determination of whether a particular bill would impose a tax for purposes of Section 3 of Article XIII A of the California Constitution is made based upon an assessment of the provisions of the bill itself.[1]

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[1] Similarly, whether a supermajority vote would be required for enactment of a bill necessarily depends on its provisions considered in their entirety. For instance, a bill that would impose a state tax does not require a two-thirds vote for purposes of Section 3 of Article XIII A of the California Constitution unless it is additionally determined that the bill's state tax provisions, taken as a whole, would increase state tax revenues. Additionally, whether the bill's provisions would trigger other bases for a supermajority vote requirement, such as an urgency clause (subd. (d), Sec. 8, Art. IV, Cal. Const.) or a General Fund appropriation for other than public schools

(continued...)

Turning to the proposal, its stated objective is to create "... an accessible, efficient, and affordable health care system that promotes a healthier California through prevention and wellness and universality of coverage" (proposal, p. 1). The proposal consists of three components: (1) prevention, health promotion, and wellness that would establish programs to promote healthy lifestyle choices, to prevent diabetes, and to prevent medical errors and health acquired infections (proposal, pp. 1 and 2); (2) universal health care coverage for all Californians (proposal, pp. 2 to 7, incl.); and (3) affordability and cost containment that would revise state tax laws to be consistent with specified federal tax law provisions relating to health care coverage and would establish various procedures and requirements to reduce the cost of health care coverage (proposal, pp. 7 to 10, incl.).

To achieve universal health care coverage, the proposal would impose an "individual mandate," as described by the proposal, requiring all Californians to secure and maintain coverage consisting, at minimum, of "... a $5,000 deductible plan with maximum out-of-pocket limits of $7,500 per person and $10,000 per family" (proposal, pp. 4 and 6). The proposal would assist low-income persons to comply with the individual mandate by expanding the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code) to include children in families with a household income up to 300 percent of the federal poverty level[2] and by creating a purchasing pool to subsidize the cost of health care coverage for legal residents with "individual or employer-sponsored coverage" who have an income between 100 and 250 percent of the federal poverty level (proposal, pp. 4, 5, and 6). The health care coverage under the purchasing pool would be "at the level of Knox-Keene[3] medical benefits plus prescription drugs," and participants' contribution amount towards the premium for this coverage would be set between three and six percent of their gross income (proposal, pp. 5 and 6). Persons who do not qualify for a subsidy would be able to purchase the minimum coverage required to satisfy the individual mandate through the purchasing pool (proposal, p. 7).

The proposal identifies five categories of state costs that would be incurred by its implementation: (1) expansion of the Medi-Cal program and the Healthy Families Program;

(...continued)
(subd. (d), Sec. 12, Art. IV, Cal. Const.), would be determined by considering all provisions of the bill.

[2] The Healthy Families Program currently provides coverage to children in families with a household income up to 250 percent of the federal poverty level (Sec. 12693.70, Ins. C.). The federal poverty level for 2007, for the continental United States, is an annual income of $20,650 for a family of four, increased by $3,480 for each additional family member (Fed. Reg., Vol. 72, Number 15, at pp. 3147-3148, January 24, 2007).

[3] The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and requires plans to provide specified benefits (Ch. 2.2 (commencing with Sec. 1340) of Division 2 of the Health and Safety Code).

(2) establishment and operation of the purchasing pool; (3) prevention and wellness measures; (4) taxation revisions; and (5) increases in the reimbursement rate under the Medi-Cal program (proposal, p. 10).

On the funding side, the proposal would require "[e]mployers with 10 or more employees who choose not to offer health coverage ... [to] contribute an amount equal to 4% of payroll toward the cost of employees' health coverage" (hereafter the employer contribution; proposal, p. 7.)[4] The proposal would also require hospitals to "... contribute 4% of gross revenues and physicians ... [to] contribute 2% of gross revenues" (hereafter the provider contribution; proposal, p. 7).[5] The employer and provider contributions would be deposited into the Health Care Services Fund, created by the proposal, and "... segregated from the state general fund and will be the source for payment of health care coverage ..." (proposal, p. 7). The proposal identifies county and state savings from eliminating certain health care coverage programs as additional revenue sources for implementation of its provisions (proposal, p. 10).

The question presented is whether either the proposed employer contribution or the proposed provider contribution would, in this context, constitute a tax for purposes of Section 3 of Article XIII A of the California Constitution (hereafter Section 3).

A statute that includes changes in state taxes for the purpose of increasing revenues is subject to the provisions of Section 3, requiring a two-thirds vote of the membership of each house of the Legislature for enactment. Section 3 reads as follows:

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[4] The employer contribution has certain similarities to Maryland's Fair Share Health Care Fund Act that would have required an employer with more than 10,000 Maryland employees to spend at least 8 percent of its payroll on employees' health care coverage or pay the difference between that amount and its actual expenditures for such coverage to the state for its Medicaid and children's health programs (*Retail Indus. Leaders Ass'n. v. Fielder* (4th Cir. 2007) 475 F.3d 180, 183; hereafter *Fielder*). A federal appellate court found that the act did not impose a tax for purposes of the federal Tax Injunction Act (28 U.S.C. Sec. 1341) but that it was preempted by the Employee Retirement Income Security Act of 1974 (Id. at pp. 188-189). Because *Fielder* was decided by a court in another jurisdiction, it is not controlling and constitutes only persuasive authority for purposes of a court's decision in this state construing this state's constitution (*Schweiger v. Superior Court of Alameda County* (1970) 3 Cal.3d 507, 513). We think, however, that *Fielder* is materially distinguishable on its facts from the proposal because evidence indicated the Maryland act would apply only to a single employer, Wal*Mart, and would likely generate no revenues, and thus the court concluded that the charge under that act served "regulatory or punitive" purposes more than revenue raising purposes (*Fielder*, supra, at pp. 183, 185, 189).

[5] Although not entirely clear from the proposal, it appears that hospitals and physicians and surgeons would also be subject to the employer contribution if they employed 10 or more persons.

"Sec. 3. From and after the effective date of this article,[6] any changes in state taxes enacted for the purpose of increasing revenues collected pursuant thereto whether by increased rates or changes in methods of computation must be imposed by an Act passed by not less than two-thirds of all members elected to each of the two houses of the Legislature, except that no new ad valorem taxes on real property, or sales or transaction taxes on the sales of real property may be imposed."

Neither Section 3 nor any other provision of Article XIII A defines taxes for purposes of applying this supermajority legislative vote requirement. Generally, taxes are described as being imposed to generate revenue to pay for a variety of public services rather than in return for conferring a specific benefit or granting a privilege, and as being compulsory in nature rather than being imposed in response to a voluntary decision to seek government privileges or benefits (*Sinclair Paint Co. v. State Bd. of Equalization* (1997) 15 Cal.4th 866, 874; hereafter *Sinclair*). Consequently, whether a levy is a tax or a fee[7] depends upon who imposes the levy, who pays the levy, and the purpose of the levy (see *San Juan Cellular Telephone v. Pub. Serv. Com'n* (1st Cir. 1992) 967 F.2d 683, 685; hereafter *San Juan*). The classic tax raises money from many or all citizens, is contributed to the general fund, and is spent for the benefit of the entire community (see *Trailer Marine Transport Corp. v. Rivera Vasquez* (1st Cir. 1992) 977 F.2d 1, 5). Whereas a fee is typically collected by an agency from a particular industry or segment of the community and used to provide "narrow benefits," or to defray the costs of regulation (*San Juan*, supra, at p. 685), to mitigate the adverse effects of the payer's activities or products (*Sinclair*, supra, at p. 870), or to defray the costs of providing services to the payer. Thus, there is a spectrum of levies, with the "classic tax" lying at one end and the fee at the other. In applying this spectrum, the court in *San Juan* stated the following:

"Courts facing cases that lie near the middle of this spectrum have tended ... to emphasize the revenue's ultimate use, asking whether it provides a general benefit to the public, of a sort often financed by a general tax, or whether it provides more narrow benefits to regulated companies or defrays the agency's costs of regulation. ..." (Ibid.)

The question of whether a particular charge constitutes a tax is a question of law, ultimately determined by a court based on its independent review of all the attendant facts (*Sinclair*, supra, at p. 874). Certain categories of charges have been identified by courts as fees that do not constitute taxes because the charge is imposed to recover the cost of services provided to the payer (*County of Fresno v. Malmstrom* (1979) 94 Cal.App.3d 974, 984), or it is an

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[6] This section was added to the Constitution by initiative measure pursuant to the approval of the electorate of Proposition 13 at the June 6, 1978, primary election.

[7] Except as otherwise specified, a government levy of a type other than a tax shall hereafter be referred to as a "fee."

assessment imposed on property or a similar business charge in an amount that reasonably reflects the value of benefits conferred on the property or business, or it is assessed in connection with property development in an amount that bears a reasonable relation to the development's costs to the community and benefits to the developer (*Sinclair*, supra, at pp. 874-875). Even where the fee is compulsory, a reasonable fee for services rendered is not a tax (*Evans v. City of San Jose* (1992) 3 Cal.App.4th 728, 735-737).

In addition to these categories, courts have classified another type of charge as a fee rather than a tax because it is imposed by the state for regulatory purposes pursuant to its police power rather than its taxing power (*Sinclair*, supra, at p. 875). Fees of this type are known as regulatory fees (Ibid.). To show that a particular charge is a valid regulatory fee, rather than a tax, the government must establish: "(1) the estimated costs of the service or regulatory activity, and (2) the basis for determining the manner in which the costs are apportioned, so that charges allocated to a payor bear a fair or reasonable relationship to the payor's burdens on or benefits from the regulatory activity" (*Sinclair*, supra, at p. 878; citing *San Diego Gas & Electric Co. v. San Diego County Air Pollution Control Dist.* (1988) 203 Cal.App.3d 1132, 1146).

A regulatory fee may be assessed in connection with a program that deters certain conduct by those subject to its terms or imposes specified requirements on them or mitigates the adverse effects caused by their operations or activities (*Sinclair*, supra, at p. 870; *United Business Com. v. City of San Diego* (1979) 91 Cal.App.3d 156, 165; *Bidart Bros. v. California Apple Comm'n.* (9th. Cir. 1996) 73 F.3d 925, 930). While a regulatory fee necessarily generates revenue to support the regulatory program with which it is associated, the principal purpose for its imposition must be regulation and not revenue generation (*Sinclair*, supra, at p. 880). Regulatory activity generally requires that the fee payer conform to certain standards and the fee supports operation of that regulatory program. If no conditions are imposed, other than paying the fee, and the fee payer carries out its business with no further conditions, then the payment is exacted solely for revenue purposes and constitutes a tax (*United Business Com. v. City of San Diego*, supra, at p. 165). "If revenue is the primary purpose and regulation is merely incidental the imposition is a tax; while if regulation is the primary purpose the mere fact that incidentally a revenue is also obtained does not make the imposition a tax ..." (Ibid., quoting *City and County of San Francisco v. Boss* (1948) 83 Cal.App.2d 445, 450).

Applying these principles to the employer contribution under the proposal, it is difficult to identify a regulatory program to which those contributions would apply. As described, the proposal would impose a mandate on all Californians to secure health care coverage. In addition, because the employer contribution is to be imposed solely on those employers who elect not to provide health care coverage to their employees, it may be argued, although it is not expressed in the proposal, that the purpose of the employer contribution is to regulate the provision of health care coverage by employers to employees. By imposing such requirements, the proposal may have certain regulatory aspects. However, no other aspects of the proposal, in our view, would directly apply to otherwise regulate the employers who are required to pay the contributions to fund the proposal's provisions. Thus, we do not believe that a court would find that the proposal would create a regulatory program with respect to those employers who elect not to provide health care coverage to their employees. We

therefore think that a court would conclude that the contributions proposed to be paid by employers are to raise revenues for a state program that is not regulatory in nature but is a program for the general benefit of the public. Consequently, we are of the view that a court would characterize the employer contribution under the proposal as a tax and not a fee to support a regulatory program.

Nevertheless, should a court find that the proposal would create a regulatory program with respect to employers, it would be necessary to next consider whether the employer contribution would constitute a valid regulatory fee. As indicated, to establish a charge as a valid regulatory fee, the government must first show the estimated costs of the service or regulatory activity. Here, the proposal estimates the total state costs for the expansion of public health care coverage programs, the Medi-Cal program and the Healthy Families Program, at $1,283,000,000 and the total state costs for the purchasing pool at $1,135,000,000 (proposal, p. 10).[8] The proposal estimates the employer contribution would generate $1,000,000,000 in revenues (proposal, p. 10). Consequently, given that the purchasing pool costs alone would exceed the total revenues generated by the employer contribution by $135,000,000, we do not think the employer contribution would be subject to classification as a tax on the basis that it would generate more revenue than the costs of the universal coverage component of the proposal. And, because it appears that all of its revenues would be expended to fund the provision of health care coverage, we do not think the employer contribution would be subject to classification as a tax on the basis of its being expended for unrelated purposes.

The government must, however, additionally show that the basis for determining the manner in which the costs of the purported regulatory program are apportioned results in an allocation bearing a fair or reasonable relationship to the payer's benefits from the regulatory activity or the social or economic "burdens" created by the payer's operations or activities (*Sinclair*, supra, at p 870, 873-876, 881). Arguably, employers would benefit under the proposal by having a healthier workforce insofar as persons with health care coverage are more likely to seek preventive care and thereby avoid serious illness. In that instance, however, we think the benefit would accrue primarily to the employee who directly benefits from better health resulting from that coverage, with the employer being only indirectly benefited. Generally, the connection or nexus between the benefit conferred by the regulatory program and the person paying the charge under it must be more direct in nature in order for the charge to constitute a regulatory fee. Otherwise, carried to its logical extreme, almost every charge assessed by the government would be susceptible to characterization as a fee to the extent certain segments of the general population are incidentally benefited by the program funded by the charge (see *Evans v. City of San Jose* supra, at p. 738).

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[8] It is unclear from the proposal whether the employer contribution would fund other components of the proposal. However, because it is described as being paid "toward the cost of employees' health coverage" and as a "... source for payment for health care coverage ..." we assume for purposes of this opinion that it would fund these particular programs (proposal, p. 7).

A perceived benefit to the payer is not essential to constitute a valid regulatory fee, however, and the determination of whether the cost allocation of a regulatory program results in a valid regulatory fee considers not only the specific benefit to the payer but also the social or economic burdens generated by the payer's operations or activities (*Sinclair*, supra, at p. 876). It could be argued that the employer contribution would mitigate the adverse effect of an employer's failure to provide health care coverage to its employees. However, to constitute a valid regulatory fee imposed for mitigation purposes, a causal connection, or nexus, must exist between the adverse effects being mitigated and the fee payer's operations or activities (*Sinclair*, supra, at p. 878). Because an employer is not required either under existing law or explicitly by the proposal to provide its employees with health care coverage, we are of the view that a court would conclude that there is not a causal connection between the employee's lack of coverage and the employer's operations or activities.

Furthermore, even if we assume that an employer's failure to provide health care coverage could be a burden to be mitigated by the proposal's provisions, it does not appear that the charge imposed on employers would, in fact, be used to mitigate that purported burden. The proposal provides that employer contributions and other moneys received under the proposal would be used to provide low-income Californians with expanded access to public programs, such as the Medi-Cal program and the Healthy Families Program, and to provide lower income working residents with financial assistance to help with the cost of coverage through a new state-administered purchasing pool (proposal, p. 4). Thus, for those employers whose employees do not come within the criteria for those programs or subsidies, the charge imposed on employers would do nothing to mitigate the purported burden of the employer's failure to provide employee health care coverage. Conversely, self-employed persons, persons employed by a business with less than 10 employees, and their dependent children would all be eligible to obtain coverage or subsidies under the proposal if they meet the criteria for the programs or subsidies despite having paid no employer contribution or having no employer contribution made on their behalf. And, even employees provided health care coverage by their employer would be eligible for "state financial assistance through the purchasing pool" if they satisfy the income criteria for participation, despite their employer being exempt from the employer contribution because of electing to offer health care coverage (proposal, p. 5).

We note that the proposal differs in this regard from the provisions of Senate Bill No. 2 of the 2003-04 Regular Session (hereafter S.B. 2) that, as described in its digest, would have required "... specified health benefits to be provided directly by [certain] employers or through the ... [State Health Purchasing Program]" created by S.B. 2. Fees paid by employers subject to S.B. 2's requirements would have been deposited into the State Health Purchasing Fund, that would have been created by the bill, and expended solely to provide health care coverage to the employees of those employers who paid the fees and to administer the fund (proposed Secs. 2140.1, 2140.4, and 2210, Lab. C.). In our view, the fee imposed on employers in S.B. 2 would have been a valid regulatory or service fee because the bill required each employer subject to its provisions to provide health care coverage to its employees, and the payment of the fee was only an alternative means that an employer could choose to comply with that requirement (see *Ehrlich v. City of Culver City* (1996) 12 Cal.4th 854, 885-886 and *Terminal*

Plaza Corp. v. City and County of San Francisco (1986) 177 Cal.App.3d 892, 905-907). The imposition of the requirement to provide health care coverage would, in our view, be a valid exercise of the state's police power, and the fee paid by an employer, being calculated on the basis of the cost to provide coverage to its employees and applied to satisfy its obligations under the program, would have constituted a valid fee.[9]

Here, however, because we discern no special benefit to employers from the proposal's provisions that would be funded by the employer contribution, nor any burdens from the employers' operations or activities to be mitigated thereby, there is, in our view, no fair or reasonable basis on which to allocate the costs of those provisions to employers for purposes of characterizing their contribution as either a regulatory fee or a fee for service.[10]

Therefore, it is our opinion that the employer contribution that would be imposed pursuant to the proposal would not constitute a fee and, as a result, would be characterized as a tax for purposes of Section 3.

We next consider whether the provider contribution would constitute a tax for purposes of Section 3. The proposal would include, as part of its universal health care coverage component, an increase in the rates paid to hospitals and to physicians and surgeons under the Medi-Cal program to encourage these providers to accept Medi-Cal patients and to reduce what the proposal characterizes as the "hidden tax" on health care coverage premiums (proposal, p. 4). According to the proposal, those premiums are increased, in part, by providers "... shift[ing] uncompensated Medi-Cal costs to other payers" that are passed along as a "hidden tax" in the form of increased premiums (proposal, p. 8). The proposal additionally identifies uncompensated costs incurred by providers treating patients without health care coverage as contributing to the "hidden tax" insofar as those costs are also shifted to other payers (proposal, pp. 3, 4, and 8).

As discussed above, a regulatory fee may be assessed in connection with a program that deters certain conduct by those subject to its terms or imposes specified requirements on them or mitigates the adverse effects caused by their operations or activities. Regulatory activity generally requires that the fee payer conform to certain standards, and the fee supports

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[9] After being chaptered (Ch. 673, Stats. 2003), S.B. 2 was submitted to the voters by referendum as Proposition 72 and was rejected by the voters at the general election on November 2, 2004.

[10] Because we reach this conclusion, we do not address the question of whether calculating the amount of the proposed employer contribution as a percentage of payroll would be a fair or reasonable means of allocating the costs of the proposal to employers. We note, however, that because of the complexity of allocating costs under a regulatory program, a precise cost-fee ratio is not required, and the government may employ a flexible assessment of proportionality retaining "... discretion to apportion the costs of proposal in a variety of reasonable financing schemes" (*California Assn. of Prof. Scientists v. Department of Fish and Game* (2000) 79 Cal.App.4th 935, 950).

operation of that regulatory program. If no conditions are imposed, other than paying the fee, and the fee payer carries out its business with no further conditions, then the payment is exacted solely for revenue purposes and constitutes a tax (*United Business Com. v. City of San Diego*, supra, at p. 165).

Applying these principles to the provider contribution under the proposal, it is difficult to identify a regulatory program to which these contributions would apply. The proposal imposes certain requirements on providers to prevent medical errors and health acquired infections (proposal, p. 2)[11]. However, we think that it is clear that the purpose of the provider contribution is not to regulate the activities of providers in that regard, but instead, to provide additional funding to remedy the so-called "hidden tax." Consequently, we are of the view that a court would characterize the provider contribution under the proposal as a tax and not a fee to support a regulatory program.

Nevertheless again, should a court find that the proposal would create a regulatory program with respect to providers, whether the proposed provider contribution would constitute a valid regulatory fee would, as discussed with respect to the employer contribution, require a showing that the costs of the purported regulatory program are apportioned in a manner that bears a fair or reasonable relationship to the payer's benefits from the regulatory activity or the social or economic "burdens" created by the payer's operations or activities (*Sinclair*, at pp. 870, 873-87, 881).

Because the proposal would increase the reimbursement rate paid under the Medi-Cal program, hospitals and physicians and surgeons who treat Medi-Cal beneficiaries would arguably benefit financially from that aspect of the proposal. However, no provider is required by existing law or would be required by the proposal to treat Medi-Cal patients, other than the requirement imposed on hospitals to provide emergency services and care to patients with a life-threatening condition or serious injury or illness regardless of insurance status or ability to pay (Sec. 1317, H.& S.C.). Because of the nature of a physician's and surgeon's practice, the services of some physicians and surgeons may be ineligible for reimbursement under the Medi-Cal program, and some physicians and surgeons may be unable to accept new patients given their current patient load. The provider contribution, however, would apportion the costs of the Medi-Cal reimbursement rate increase among all hospitals and physicians and surgeons, making no exemption for a physician and surgeon or a hospital that elected not to

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[11] The proposal includes "preventing medical errors and health acquired infections" as part of its prevention, health promotion, and wellness component and identifies requirements that would be imposed on providers pursuant to that objective (proposal, p. 2). The proposal estimates the total state costs for this component at $150,000,000 but does not specify the amount that would be expended on preventing medical errors and health acquired infections or whether the provider contribution would fund this particular aspect of the proposal (proposal, p. 10).

accept additional Medi-Cal patients despite the increased reimbursement rate or for a physician and surgeon who would be unable to increase his or her practice by accepting new patients.

A charge does not constitute a tax simply because it is disproportionate as to the benefits accruing to one or another of the payer classes (*Brydon v. East Bay Mun. Utility Dist.* (1994) 24 Cal.App.4th 178, 194). Nevertheless, under the proposal, the provider contribution would be imposed on parties who would be entirely precluded from enjoying the purported benefits of the increased Medi-Cal rates under the proposal and, as a result, we think this allocation of costs would not be found to bear a fair or reasonable relationship to this purported benefit. Moreover, similarly to the employer contribution, we think the benefit of an increased reimbursement rate paid under the Medi-Cal program would accrue more directly to the beneficiaries of that program than the providers paying the contribution. The proposal states that Medi-Cal patients resort to obtaining treatment at hospital emergency departments because they "... have problems accessing physicians through government programs such as Medi-Cal ..." (proposal, p. 3). To the extent additional physicians and surgeons would participate in the Medi-Cal program as a result of the increased reimbursement rate, Medi-Cal patients, in our view, would directly benefit from having a greater choice for providers and from better health resulting from establishing a relationship with a physician and surgeon and thereby receiving preventive care. Conversely, the proposal recognizes that the existing rate paid under the Medi-Cal program does not fairly compensate physicians and surgeons and hospitals for their services (proposal, pp. 3, 4, and 8). By increasing that rate, the proposal arguably would only more justly compensate these providers for their care of Medi-Cal patients.

Physicians and surgeons and hospitals may also arguably benefit from the proposal's program to establish a universal health care coverage system insofar as those programs would secure a source of payment for their services. However, as with the Medi-Cal rate increase, we think these programs would only more justly compensate the providers for the care provided to patients, with the benefit accruing principally to persons who would obtain health care coverage under the proposal and obtain better medical care as a result. As the proposal indicates, increasing the Medi-Cal reimbursement rate and providing for universal health care coverage would reduce or eliminate the "hidden tax" on health care costs resulting from providers shifting uncompensated costs to other payers (proposal, pp. 3, 4, and 8). However, as recognized by the proposal, "[a]ddressing the 'hidden tax' benefits everyone" by reducing the costs of health care coverage and the burden on hospital emergency departments from treating Medi-Cal patients and persons without health care coverage (proposal, pp. 3 and 8). Where an assessment is expended to provide a general benefit to the public, it is ordinarily considered to constitute a tax and not a fee (*Bidart Bros. v. California Apple Comm'n.*, supra, at p. 932).

In addition, we find it difficult to identify any adverse effects caused by the operations of hospitals and of physicians and surgeons that would be mitigated by the revenue generated by the provider contribution under the proposal. It could be argued that the provider contribution would mitigate the adverse effects of the increase in premium amounts for health care coverage resulting from providers shifting costs to other payers, creating, as described by the proposal, the "hidden tax." As discussed above, in order to constitute a valid regulatory fee imposed for mitigation purposes, a causal connection, or nexus, must exist between the adverse

effects being mitigated and the payers' operations or activities (*Sinclair*, supra, at p. 878). The proposal indicates that the "hidden tax" results from providers being under compensated for services provided to beneficiaries of the Medi-Cal program and being uncompensated for services provided to patients without health care coverage. Consequently, we think these factors are the cause of the "hidden tax" because absent the lack of compensation, providers would not be required to shift costs to other payers. We do not think an adequate nexus exists between the providers' activities and the "hidden tax" on health care coverage premiums as required to characterize the provider contribution as a valid regulatory fee imposed for mitigation purposes.

In summary, the physicians and surgeons and hospitals required to pay the provider contribution would, in our view, not be subject to any valid regulatory program, and would realize no special benefit from the proposal nor would a nexus exist between the activities or operations of these providers and the problems addressed by the proposal. Therefore, it is our opinion that the provider contribution that would be imposed pursuant to the proposal would not constitute a fee and, as a result, would be characterized as a tax for purposes of Section 3.

In conclusion, it is our opinion that the charges proposed to be assessed against certain employers and against physicians and surgeons and hospitals by Governor Schwarzenegger's Health Care Proposal would, if enacted, constitute a tax for purposes of Section 3 of Article XIII A of the California Constitution.

Very truly yours,

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